

105TH CONGRESS
1ST SESSION

S. 346

To assure fairness and choice to patients and health care providers, and
for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 24, 1997

Mr. WELLSTONE introduced the following bill; which was read twice and
referred to the Committee on Labor and Human Resources

A BILL

To assure fairness and choice to patients and health care
providers, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Patient Protection Act of 1997”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act are as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Definitions.

TITLE I—OFFICE FOR CONSUMER INFORMATION, COUNSELING
AND ASSISTANCE WITH HEALTH CARE

Sec. 101. Establishment.

TITLE II—UTILIZATION MANAGEMENT

- Sec. 201. Definitions.
 Sec. 202. Requirement for utilization review program.
 Sec. 203. Standards for utilization review.

TITLE III—HEALTH PLAN STANDARDS

- Sec. 301. Health plan standards.
 Sec. 302. Minimum solvency requirements.
 Sec. 303. Information on terms of plan.
 Sec. 304. Access.
 Sec. 305. Credentialing for health providers.
 Sec. 306. Grievance procedures.
 Sec. 307. Confidentiality standards.
 Sec. 308. Discrimination.
 Sec. 309. Prohibition on selective marketing.

TITLE IV—MISCELLANEOUS PROVISIONS

- Sec. 401. Enforcement.
 Sec. 402. Effective date.
 Sec. 403. Preemption.

1 **SEC. 2. DEFINITIONS.**

2 Unless specifically provided otherwise, as used in this
 3 Act:

4 (1) CARRIER.—The term “carrier” means a li-
 5 censed insurance company, a hospital or medical
 6 service corporation (including an existing Blue Cross
 7 or Blue Shield organization, within the meaning of
 8 section 833(c)(2) of Internal Revenue Code of 1986
 9 as in effect before the date of the enactment of this
 10 Act), a health maintenance organization, or other
 11 entity licensed or certified by the State to provide
 12 health insurance or health benefits.

13 (2) COVERED INDIVIDUAL.—The term “covered
 14 individual” means a member, enrollee, subscriber,

1 covered life, patient or other individual eligible to re-
2 ceive benefits under a health plan.

3 (3) EMERGENCY SERVICES.—The term “emer-
4 gency services” means those health care services
5 that are provided to a patient after the sudden onset
6 of a health condition that manifests itself by symp-
7 toms of sufficient severity, including severe pain,
8 and the absence of such immediate health care at-
9 tention could reasonably be expected, to result in—

10 (A) placing the patient’s health in serious
11 jeopardy;

12 (B) serious impairment to bodily function;

13 or

14 (C) serious dysfunction of any bodily organ
15 or part.

16 (4) HEALTH PLAN.—The term “health plan”
17 includes any organization that seeks to arrange for,
18 or provide for the financing and coordinated delivery
19 of, health care services directly or through a con-
20 tracted health provider panel, and shall include
21 health maintenance organizations, preferred provider
22 organizations, single service health maintenance or-
23 ganizations, single service preferred provider organi-
24 zations, other entities such as provider-hospital or
25 hospital-provider organizations, employee welfare

1 benefit plans (as defined in section 3(1) of the Em-
 2 ployee Retirement Income Security Act of 1974 (29
 3 U.S.C. 1002(1)), and multiple employer welfare
 4 plans or other association plans, as well as carriers.

5 (5) HEALTH PROVIDER.—The term “health
 6 provider” means an individual who is licensed or cer-
 7 tified under State law to provide health care services
 8 and who is operating within the scope of such licen-
 9 sure or certification.

10 (6) MANAGED CARE PLAN.—

11 (A) IN GENERAL.—The term “managed
 12 care plan” means a plan operated by a man-
 13 aged care entity (as defined in subparagraph
 14 (B)), that provides for the financing and deliv-
 15 ery of health care services to persons enrolled in
 16 such plan through—

17 (i) arrangements with selected provid-
 18 ers to furnish health care services;

19 (ii) explicit standards for the selection
 20 of participating providers;

21 (iii) organizational arrangements for
 22 ongoing quality assurance, utilization re-
 23 view programs, and dispute resolution; and

1 (iv) financial incentives for persons
2 enrolled in the plan to use the participat-
3 ing providers and procedures provided for
4 by the plan.

5 (B) MANAGED CARE ENTITY.—The term
6 “managed care entity” includes a licensed in-
7 surance company, hospital or medical service
8 plan (including provider and provider-hospital
9 networks), health maintenance organization, an
10 employer or employee organization, or a man-
11 aged care contractor (as defined in subpara-
12 graph (C)), that operates a managed care plan.

13 (C) MANAGED CARE CONTRACTOR.—The
14 term “managed care contractor” means a per-
15 son that—

16 (i) establishes, operates, or maintains
17 a network of participating providers;

18 (ii) conducts or arranges for utiliza-
19 tion review activities; and

20 (iii) contracts with an insurance com-
21 pany, a hospital or health service plan, an
22 employer, an employee organization, or any
23 other entity providing coverage for health
24 care services to operate a managed care
25 plan.

1 (7) PROVIDER NETWORK.—The term “provider
2 network” means, with respect to a health plan that
3 restricts access, those providers who have entered
4 into a contract or agreement with the plan under
5 which such providers are obligated to provide items
6 and services under the plan to eligible individuals
7 enrolled in the plan, or have an agreement to pro-
8 vide services on a fee-for-service basis.

9 (8) SECRETARY.—The term “Secretary” means
10 the Secretary of Health and Human Services unless
11 specifically provided otherwise.

12 (9) SPECIALIZED TREATMENT EXPERTISE.—
13 The term “specialized treatment expertise” means
14 expertise in diagnosing and treating unusual dis-
15 eases and conditions, diagnosing and treating dis-
16 eases and conditions that are usually difficult to di-
17 agnose or treat, and providing other specialized
18 health care.

19 (10) SPONSOR.—The term “sponsor” means a
20 carrier or employer that provides a health plan.

21 (11) UTILIZATION REVIEW.—The term “utiliza-
22 tion review” means a set of formal techniques de-
23 signed to monitor and evaluate the clinical necessity,
24 appropriateness and efficiency of health care serv-
25 ices, procedures, providers and facilities. Techniques

1 may include ambulatory review, prospective review,
 2 second opinion, certification, concurrent review, case
 3 management, discharge planning and retrospective
 4 review.

5 **TITLE I—OFFICE FOR**
 6 **CONSUMER INFORMATION,**
 7 **COUNSELING AND ASSIST-**
 8 **ANCE WITH HEALTH CARE**

9 **SEC. 101. ESTABLISHMENT.**

10 (a) IN GENERAL.—The Secretary shall award a grant
 11 to each State and each State shall use amounts received
 12 under the grant to establish an Office for Consumer Infor-
 13 mation, Counseling and Assistance with Health Care (re-
 14 ferred to in this section as the “Office”). Each such Office
 15 shall perform public outreach and provide education and
 16 assistance concerning consumer rights with respect to
 17 health insurance and benefits as provided for in subsection
 18 (d).

19 (b) USE OF GRANT.—

20 (1) IN GENERAL.—A State shall use a grant
 21 under this section—

22 (A) to administer the Office and carry out
 23 the duties described in subsection (d);

24 (B) to solicit and award contracts to pri-
 25 vate, nonprofit organizations applying to the

1 State to administer the Office and carry out the
2 duties described in subsection (d); or

3 (C) in the case of a State operating a
4 consumer information counseling and assistance
5 program on the date of enactment of this Act,
6 to expand and improve such program.

7 (2) CONTRACTS.—With respect to the contract
8 described in paragraph (1)(B), the contract period
9 shall be not less than 2 years and not more than 4
10 years.

11 (c) STAFF.—A State shall ensure that the Office has
12 sufficient staff (including volunteers) and local offices
13 throughout the State to carry out its duties under this
14 section and a demonstrated ability to represent and work
15 with a broad spectrum of consumers, including vulnerable
16 and underserved populations.

17 (d) DUTIES.—An Office established under this sec-
18 tion shall—

19 (1) establish a State-wide toll-free hotline to en-
20 able consumers to contact the Office;

21 (2) have the ability to provide culturally appro-
22 priate assistance that as far as practicable takes into
23 consideration under this subsection language needs;

1 (3) develop outreach programs to provide health
2 insurance and health benefits information, counsel-
3 ing, and assistance;

4 (4) provide outreach and education relating to
5 consumer rights and responsibilities under this Act,
6 including the rights and services available through
7 the Office;

8 (5) provide individuals with assistance in enroll-
9 ing in health plans (including providing plan com-
10 parisons), or in obtaining services or reimbursements
11 from health plans;

12 (6) provide individuals with assistance in filing
13 applications for appropriate State health plan pre-
14 mium assistance programs;

15 (7) provide individuals with information and ad-
16 vocacy concerning existing grievance procedures and
17 institute systems of referral to appropriate Federal
18 or State departments or agencies for assistance with
19 problems related to insurance coverage (including
20 legal problems);

21 (8) ensure that regular and timely access is
22 provided to the services available through the Office;

23 (9) implement training programs for staff mem-
24 bers (including volunteer staff members) and collect

1 and disseminate timely and accurate health care in-
 2 formation to staff members;

3 (10) not less than once each year, conduct pub-
 4 lic hearings to identify and address community
 5 health care needs;

6 (11) coordinate its activities with the staff of
 7 the appropriate departments and agencies of the
 8 State government and other appropriate entities
 9 within the State; and

10 (12) carry out any other activities determined
 11 appropriate by the Secretary.

12 (e) STATE DUTIES.—

13 (1) ACCESS TO INFORMATION.—The State shall
 14 ensure that, for purposes of carrying out the duties
 15 of the Office, the Office has appropriate access to
 16 relevant information, subject to the application of
 17 procedures to ensure confidentiality of enrollee and
 18 proprietary health plan information.

19 (2) REPORTING AND EVALUATION REQUIRE-
 20 MENTS.—

21 (A) REPORT.—The Office shall annually
 22 prepare and submit to the State a report on the
 23 nature and patterns of consumer complaints re-
 24 ceived by the Office during the year for which

the report is prepared. Such report shall contain any policy, regulatory, and legislative recommendations for improvements in the activities of the Office together with a record of the activities of the Office.

(B) EVALUATION.—The State shall annually evaluate the quality and effectiveness of the Office in carrying out the activities described in subsection (d).

(3) CONFLICTS OF INTEREST.—The State shall ensure that no individual involved in selecting the entity with which to enter into a contract under subsection (b)(1)(B), or involved in the operation of the Office, or any delegate of the Office, is subject to a conflict of interest.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

TITLE II—UTILIZATION MANAGEMENT

SEC. 201. DEFINITIONS.

As used in this title:

(1) ADVERSE DETERMINATION.—The term “adverse determination” means a determination that an admission to or continued stay at a hospital or that

1 another health care service that is required has been
2 reviewed and, based upon the information provided,
3 does not meet the requirements for clinical necessity,
4 appropriateness, level of care, or effectiveness.

5 (2) AMBULATORY REVIEW.—The term “ambu-
6 latory review” means utilization review of health
7 care services performed or provided in an outpatient
8 setting.

9 (3) APPEALS PROCEDURE.—The term “appeals
10 procedure” means a formal process under which a
11 covered individual (or an individual acting on behalf
12 of a covered individual), attending provider or facil-
13 ity may appeal an adverse utilization review decision
14 rendered by the health plan or its designee utiliza-
15 tion review organization.

16 (4) CARE COORDINATOR.—The term “care co-
17 ordinator” means a health provider who performs
18 case management functions in consultation with the
19 interdisciplinary health care team, the patient, fam-
20 ily, and community.

1 (5) CASE MANAGEMENT.—The term “case man-
2 agement” means a coordinated set of activities con-
3 ducted for the individual patient management of se-
4 rious, complicated, protracted or chronic health con-
5 ditions that provides cost-effective and benefit-maxi-
6 mizing treatments for extremely resource-intensive
7 conditions.

8 (6) CLINICAL REVIEW CRITERIA.—The term
9 “clinical review criteria” means the recorded (writ-
10 ten or otherwise) screening procedures, decision ab-
11 stracts, clinical protocols and practice guidelines
12 used by the health plan to determine necessity and
13 appropriateness of health care services.

14 (7) COMPARABLE.—The term “comparable”
15 means a health provider who is licensed or certified
16 in a manner that permits the provider to authorize
17 the equipment, services, or procedures that are the
18 subject of a review.

19 (8) CONCURRENT REVIEW.—The term “concur-
20 rent review” means utilization review conducted dur-
21 ing a patient’s hospital stay or course of treatment.

1 (9) DISCHARGE PLANNING.—The term “dis-
2 charge planning” means the formal process for de-
3 termining, coordinating and managing the care a pa-
4 tient receives following the discharge of the patient
5 from a facility.

6 (10) FACILITY.—The term “facility” means an
7 institution or health care setting providing the pre-
8 scribed health care services under review. Such term
9 includes hospitals and other licensed inpatient facili-
10 ties, ambulatory surgical or treatment centers,
11 skilled nursing facilities, residential treatment cen-
12 ters, diagnostic, laboratory and imaging centers and
13 rehabilitation and other therapeutic health care set-
14 tings.

15 (11) PROSPECTIVE REVIEW.—The term “pro-
16 spective review” means utilization review conducted
17 prior to an admission or a course of treatment.

18 (12) RETROSPECTIVE REVIEW.—The term “ret-
19 rospective review” means utilization review con-
20 ducted after health care services have been provided
21 to a patient. Such term does not include the retro-
22 spective review of a claim that is limited to an eval-
23 uation of reimbursement levels, veracity of docu-
24 mentation, accuracy of coding and adjudication for
25 payment.

1 (13) SECOND OPINION.—The term “second
2 opinion” means an opportunity or requirement to
3 obtain a clinical evaluation by a provider other than
4 the provider originally making a recommendation for
5 a proposed health service to assess the clinical neces-
6 sity and appropriateness of the initial proposed
7 health service.

8 (14) UTILIZATION REVIEW ORGANIZATION.—
9 The term “utilization review organization” means an
10 entity that conducts utilization review.

11 **SEC. 202. REQUIREMENT FOR UTILIZATION REVIEW PRO-**
12 **GRAM.**

13 A health plan shall have in place a utilization review
14 program that meets the requirements of this title and that
15 is certified by the State.

16 **SEC. 203. STANDARDS FOR UTILIZATION REVIEW.**

17 (a) ESTABLISHMENT.—The Secretary of Health and
18 Human Services, in consultation with the Secretary of
19 Labor (referred to in this title as the “Secretaries”), shall
20 establish standards for the establishment, operation, and
21 certification and periodic recertification of health plan uti-
22 lization review programs.

23 (b) ALTERNATIVE STANDARDS.—

24 (1) IN GENERAL.—A State may certify a health
25 plan as meeting the standards established under

1 subsection (a) if the State determines that the
2 health plan has met the utilization standards re-
3 quired for accreditation as applied by a nationally
4 recognized, independent, nonprofit accreditation en-
5 tity.

6 (2) REVIEW BY STATE.—A State that makes a
7 determination under paragraph (1) shall periodically
8 review the standards used by the private accredita-
9 tion entity to ensure that such standards meet or ex-
10 ceed the standards established by the Secretaries
11 under this title.

12 (c) UTILIZATION REVIEW PROGRAM REQUIRE-
13 MENTS.—The standards developed by the Secretaries
14 under subsection (a) shall require that utilization review
15 programs comply with the following:

16 (1) DOCUMENTATION.—A health plan shall pro-
17 vide a written description of the utilization review
18 program of the plan, including a description of—

19 (A) any activities assigned from the health
20 plan to other entities;

21 (B) the policies and procedures used under
22 the program to evaluate clinical necessity; and

1 (C) the clinical review criteria, information
2 sources, and the process used to review and ap-
3 prove the provision of health care services under
4 the program.

5 (2) PROHIBITION.—With respect to the admin-
6 istration of the utilization review program, a health
7 plan may not employ utilization reviewers or con-
8 tract with a utilization management organization if
9 the conditions of employment or the contract terms
10 include financial incentives to reduce or limit the
11 provision of clinically necessary or appropriate serv-
12 ices to covered individuals.

13 (3) REVIEW AND MODIFICATION.—A health
14 plan shall develop procedures for periodically review-
15 ing and modifying the utilization review of the plan.
16 Such procedures shall provide for the participation
17 of providers and consumers in the health plan in the
18 development and review of utilization review policies
19 and procedures.

20 (4) DECISION PROTOCOLS.—

21 (A) IN GENERAL.—A utilization review
22 program shall develop and apply recorded (writ-
23 ten or otherwise) utilization review decision pro-
24 tocols. Such protocols shall be based on sound
25 health care evidence.

1 (B) PROTOCOL CRITERIA.—The clinical re-
2 view criteria used under the utilization review
3 decision protocols to assess the appropriateness
4 of health care services shall be clearly docu-
5 mented and available to participating health
6 providers upon request. Such protocols shall in-
7 clude a mechanism for assessing the consistency
8 of the application of the criteria used under the
9 protocols across reviewers, and a mechanism for
10 periodically updating such criteria.

11 (5) REVIEW AND DECISIONS.—

12 (A) REVIEW.—The procedures applied
13 under a utilization review program with respect
14 to the preauthorization and concurrent review
15 of the necessity and appropriateness of health
16 care devices, services or procedures, shall re-
17 quire that qualified, comparable health care
18 providers supervise review decisions. With re-
19 spect to a decision to deny the provision of
20 health care devices, services or procedures, a
21 comparable provider shall conduct a subsequent
22 review to determine the clinical appropriateness
23 of such a denial. Comparable health providers
24 from the appropriate specialty area shall be uti-
25 lized in the review process.

1 (B) DECISIONS.—All utilization review de-
2 cisions shall be made in a timely manner, as de-
3 termined appropriate when considering the ur-
4 gency of the situation.

5 (C) ADVERSE DETERMINATIONS.—With re-
6 spect to utilization review, an adverse deter-
7 mination or noncertification of an admission,
8 continued stay, or service shall be clearly docu-
9 mented, including the specific clinical or other
10 reason for the adverse determination or noncer-
11 tification, and be available to the covered indi-
12 vidual and the affected provider or facility. A
13 health plan may not deny or limit coverage with
14 respect to a service that the enrollee has al-
15 ready received solely on the basis of lack of
16 prior authorization or second opinion, to the ex-
17 tent that the service would have otherwise been
18 covered by the plan had such prior authoriza-
19 tion or a second opinion been obtained.

20 (D) NOTIFICATION OF DENIAL.—A health
21 plan shall provide a covered individual with
22 timely notice of an adverse determination or
23 noncertification of an admission, continued

1 stay, or service. Such a notification shall in-
2 clude information concerning the utilization re-
3 view program appeals procedure as well as the
4 telephone number for the Office.

5 (6) REQUESTS FOR AUTHORIZATION.—A health
6 plan utilization review program shall ensure that re-
7 quests by covered individuals or providers for prior
8 authorization of a nonemergency service shall be an-
9 swered in a timely manner after such request is re-
10 ceived. If utilization review personnel are not avail-
11 able in a timely fashion, any health care services
12 provided shall be considered approved.

13 (7) NEW TECHNOLOGIES.—A utilization review
14 program shall implement policies and procedures to
15 evaluate the appropriate use of new health care tech-
16 nologies or new applications of established tech-
17 nologies, including health care procedures, drugs,
18 and devices. The program shall ensure that appro-
19 priate providers participate in the development of
20 technology evaluation criteria.

21 (8) SPECIAL RULE.—Where prior authorization
22 for a service or other covered item is obtained under
23 a program under this section, the service shall be
24 considered to be covered unless there was intentional
25 fraud or intentionally incorrect information provided

1 at the time such prior authorization was obtained. If
 2 a provider intentionally supplied the incorrect infor-
 3 mation that led to the authorization of clinically un-
 4 necessary care, the provider shall be prohibited from
 5 collecting payment directly from the enrollee, and
 6 shall reimburse the plan and subscriber for any pay-
 7 ments or copayments the provider may have re-
 8 ceived.

9 (d) HEALTH PLAN REQUIREMENTS.—

10 (1) DISCLOSURE OF INFORMATION.—

11 (A) PROSPECTIVE COVERED INDIVID-
 12 UALS.—A health plan shall, with respect to any
 13 materials distributed to prospective covered in-
 14 dividuals, include a summary of the utilization
 15 review procedures of the plan.

16 (B) COVERED INDIVIDUALS.—A health
 17 plan shall, with respect to any materials distrib-
 18 uted to newly covered individuals, include a
 19 clear and comprehensive description of utiliza-
 20 tion review procedures of the plan and a state-
 21 ment of patient rights and responsibilities with
 22 respect to such procedures.

23 (C) STATE OFFICIALS.—

1 (i) IN GENERAL.—A health plan shall
2 disclose to the State insurance commis-
3 sioner, or other designated State official,
4 the health plan utilization review program
5 policies, procedures, and reports required
6 by the State for certification.

7 (ii) STREAMLINING OF PROCE-
8 DURES.—To the extent practicable, a State
9 shall implement procedures to streamline
10 the process by which a health plan docu-
11 ments compliance with the requirements of
12 this Act, including procedures to condense
13 the number of documents filed with the
14 State concerning such compliance.

15 (2) TOLL-FREE NUMBER.—A health plan shall
16 have a membership card which shall have printed on
17 the card the toll-free telephone number that a cov-
18 ered individual should call to receive precertification
19 utilization review decisions.

20 (3) EVALUATION.—A health plan shall establish
21 mechanisms to evaluate the effects of the utilization
22 review program of the plan through the use of mem-
23 ber satisfaction data or through other appropriate
24 means.

25 (e) EMERGENCY CARE.—

1 (1) EMERGENCY MEDICAL CONDITION.—For
 2 purposes of this section the term ‘emergency medical
 3 condition’ means a medical condition manifesting it-
 4 self by acute symptoms of sufficient severity (includ-
 5 ing severe pain) such that a prudent layperson (in-
 6 cluding the parent of a minor child or the guardian
 7 of a disabled individual), who possesses an average
 8 knowledge of health and medicine, could reasonably
 9 expect the absence of immediate medical attention to
 10 result in—

11 (A) placing the health of the individual (or,
 12 with respect to a pregnant woman, the health
 13 of the woman or her unborn child) in serious
 14 jeopardy,

15 (B) serious impairment to bodily functions,
 16 or

17 (C) serious dysfunction of any bodily organ
 18 or part.

19 (2) PREAUTHORIZATION.—With respect to
 20 emergency services furnished in a hospital emer-
 21 gency department, a health plan shall not require
 22 prior authorization for the provision of such services
 23 if the enrollee arrived at the emergency department
 24 with symptoms that reasonably suggested an emer-
 25 gency medical condition based on the judgment of a

prudent layperson, regardless of whether the hospital was affiliated with the health plan. All procedures performed during the evaluation and treatment of an emergency medical condition shall be covered under the health plan.

TITLE III—HEALTH PLAN STANDARDS

SEC. 301. HEALTH PLAN STANDARDS.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, in conjunction with the Secretary of Labor (referred to in this title as the “Secretaries”), shall establish standards for the certification and periodic recertification of health plans, including standards which require plans to meet the requirements of this title.

(b) STATE CERTIFICATION.—

(1) IN GENERAL.—A State shall provide for the certification of health plans if the certifying authority designated by the State determines that the plan meets the applicable requirements of this Act.

(2) REQUIREMENT.—Effective on January 1, 1999, a health plan sponsor may only offer a health plan in a State if such plan is certified by the State under paragraph (1).

(c) CONSTRUCTION.—Whenever in this title a requirement or standard is imposed on a health plan, the

1 requirement or standard is deemed to have been imposed
2 on the sponsor of the plan in relation to that plan.

3 **SEC. 302. MINIMUM SOLVENCY REQUIREMENTS.**

4 (a) IN GENERAL.—Except as provided in subsection
5 (b), each State shall apply minimum solvency require-
6 ments to all health plans offered or operating within the
7 State to ensure the fiscal integrity of such plans. A health
8 plan shall meet the financial reserve requirements that are
9 established by the State to assure proper payment for
10 health care services provided under the plan. Such require-
11 ments may include plan participation in a mechanism to
12 provide for indemnification of plan failures even if a plan
13 has met the reserve requirements.

14 (b) FEDERAL STANDARDS.—The Secretaries shall es-
15 tablish minimum solvency standards that shall apply to
16 all self-insured health plans. Such standards shall at least
17 meet the solvency requirements established by the Na-
18 tional Association of Insurance Commissioners.

1 **SEC. 303. INFORMATION ON TERMS OF PLAN.**

2 (a) IN GENERAL.—A health plan shall provide pro-
 3 spective covered individuals with written information con-
 4 cerning the terms and conditions of the health plan to en-
 5 able such individuals to make informed decisions with re-
 6 spect to a certain system of health care delivery. Such in-
 7 formation shall be standardized so that prospective cov-
 8 ered individuals may compare the attributes of all such
 9 plans offered within the coverage area.

10 (b) UNDERSTANDABILITY.—Information provided
 11 under this section, whether written or oral shall be easily
 12 understandable, truthful, linguistically appropriate and
 13 objective with respect to the terms used. Descriptions pro-
 14 vided in such information shall be consistent with stand-
 15 ards developed for supplemental insurance coverage under
 16 title XVIII of the Social Security Act (42 U.S.C. 1395
 17 et seq.).

18 (c) REQUIRED INFORMATION.—Information required
 19 under this section shall include information concerning—

20 (1) coverage provisions, benefits, and any exclu-
 21 sions by category of service or product;

22 (2) plan loss ratios with an explanation that
 23 such ratios reflect the percentage of the premiums
 24 expended for health services;

25 (3) prior authorization or other review require-
 26 ments including preauthorization review, concurrent

1 review, post-service review, post-payment review and
2 procedures that may lead the patient to be denied
3 coverage for, or not be provided, a particular service
4 or product;

5 (4) an explanation of how plan design impacts
6 enrollees, including information on the financial re-
7 sponsibility of covered individuals for payment for
8 coinsurance or other out-of-plan services;

9 (5) covered individual satisfaction statistics, in-
10 cluding disenrollment statistics and satisfaction sta-
11 tistics from those who disenroll;

12 (6) advance directives and organ donation;

13 (7) the characteristics and availability of health
14 care providers and institutions participating in the
15 plan, including descriptions of the financial arrange-
16 ments or contractual provisions with hospitals, utili-
17 zation review organizations, physicians, or any other
18 provider of health care services that would affect the
19 services offered, referral or treatment options, or
20 provider's fiduciary responsibility to patients, includ-
21 ing financial incentives regarding the provision of
22 services; and

23 (8) quality indicators for the plan and for par-
24 ticipating health providers under the plan, including
25 population-based statistics such as immunization

1 rates and performance measures such as survival
2 after surgery, adjusted for case mix.

3 **SEC. 304. ACCESS.**

4 (a) IN GENERAL.—A health plan shall demonstrate
5 that the plan has a sufficient number, distribution, and
6 variety of qualified health care providers to ensure that
7 all covered health care services will be available and acces-
8 sible in a timely manner to adults, infants, children, and
9 individuals with disabilities enrolled in the plan. Plans
10 shall make reasonable efforts to address issues of cultural
11 competence and appropriateness with respect to providers.

12 (b) AVAILABILITY OF SERVICES.—A health plan shall
13 ensure that services covered under the plan are available
14 in a timely manner that ensures a continuity of care, are
15 accessible within a reasonable proximity to the residences
16 of the enrollees, are available within reasonable hours of
17 operation, and include emergency and urgent care services
18 when clinically necessary and available which shall be ac-
19 cessible within the service area 24-hours a day, seven days
20 a week.

21 (c) SPECIALIZED TREATMENT.—A health plan shall
22 demonstrate that plan enrollees have meaningful access,
23 when clinically indicated in the judgment of the treating
24 health provider, to specialized treatment expertise.

25 (d) CHRONIC CONDITIONS.—

1 (1) IN GENERAL.—Any process established by a
 2 health plan to coordinate care and control costs may
 3 not impose an undue burden on enrollees with
 4 chronic health conditions. The plan shall ensure a
 5 continuity of care and shall, when clinically indicated
 6 in the judgment of the treating health provider, en-
 7 sure ongoing direct access to relevant specialists for
 8 continued care.

9 (2) CARE COORDINATOR.—In the case of an en-
 10 rollee who has a severe, complex, or chronic condi-
 11 tion, the health plan shall determine, based on the
 12 judgment of the treating health provider, whether it
 13 is clinically necessary or appropriate to use a care
 14 coordinator from an interdisciplinary team.

15 (e) REQUIREMENT.—

16 (1) IN GENERAL.—The requirements of this
 17 section may not be waived and shall be met in all
 18 areas where the health plan has enrollees, including
 19 rural areas. With respect to children, such services
 20 shall include pediatric and pediatric specialty serv-
 21 ices.

22 (2) OUT-OF-NETWORK SERVICES.—If a health
 23 plan fails to meet the requirements of this section,
 24 the plan shall arrange for the provision of out-of-

1 network services to enrollees in a manner that pro-
 2 vides enrollees with access to services in accordance
 3 with the principles and parameters set forth in this
 4 section.

5 **SEC. 305. CREDENTIALING FOR HEALTH PROVIDERS.**

6 (a) IN GENERAL.—A health plan shall credential
 7 health providers furnishing health care services under the
 8 plan.

9 (b) CREDENTIALING PROCESS.—

10 (1) IN GENERAL.—A health plan shall establish
 11 a credentialing process. Such process shall ensure
 12 that a health provider is credentialed prior to that
 13 provider being listed as a health provider in the
 14 health plan’s marketing materials, in accordance
 15 with recorded (written or otherwise) policies and
 16 procedures.

17 (2) RESPONSIBILITY CHIEF HEALTH CARE OF-
 18 FICER.—The chief health care officer of the health
 19 plan, or another designated health provider, shall
 20 have responsibility for the credentialing of health
 21 providers under the plan.

22 (3) UNIFORM APPLICATIONS.—A State shall de-
 23 velop a basic uniform application that shall be used
 24 by all health plans in the State for credentialing
 25 purposes.

1 (4) STANDARDS.—

2 (A) IN GENERAL.—Credentialing decisions
3 under a health plan shall be based on objective
4 standards with input from health providers
5 credentialed under the plan. Information con-
6 cerning all application and credentialing policies
7 and procedures shall be made available for re-
8 view by the health providers involved upon writ-
9 ten request.

10 (B) RIGHT TO REVIEW INFORMATION.—A
11 health provider who undergoes the credentialing
12 process shall have the right to review the basis
13 information, including the sources of that infor-
14 mation, that was used to meet the designated
15 credentialing criteria.

16 **SEC. 306. GRIEVANCE PROCEDURES.**

17 (a) IN GENERAL.—A health plan shall adopt a timely
18 and organized system for resolving complaints and formal
19 grievances filed by covered individuals. Such system shall
20 include—

21 (1) recorded (written or otherwise) procedures
22 for registering and responding to complaints and
23 grievances in a timely manner;

24 (2) documentation concerning the substance of
25 complaints, grievances, and actions taken concerning

1 such complaints and grievances, which shall be in
2 writing, and be available upon request to the Office
3 for Consumer Information, Counseling and Assist-
4 ance with Health Care;

5 (3) procedures to ensure a resolution of a com-
6 plaint or grievance;

7 (4) the compilation and analysis of complaint
8 and grievance data;

9 (5) procedures to expedite the complaint proc-
10 ess if the complaint involves a dispute about the cov-
11 erage of an immediately and urgently needed service;
12 and

13 (6) procedures to ensure that if an enrollee
14 orally notifies a health plan about a complaint, the
15 plan (if requested) must send the enrollee a com-
16 plaint form that includes the telephone numbers and
17 addresses of member services, a description of the
18 plan's grievance procedure, and the telephone num-
19 ber of the Officer for Consumer Information, Coun-
20 seling and Assistance with Health Care where enroll-
21 ees may register complaints.

22 (b) APPEAL PROCESS.—A health plan shall adopt an
23 appeals process to enable covered individuals and provid-
24 ers to appeal decisions that are adverse to the covered in-
25 dividuals. Such a process shall include—

- 1 (1) the right to a review by a grievance panel;
- 2 (2) the right to a second review with a different
- 3 panel, independent from the health plan; and
- 4 (3) an expedited process for review in emer-
- 5 gency cases.

6 The Secretaries shall develop guidelines for the structure
7 and requirements applicable to the independent review
8 panel.

9 (c) NOTIFICATION.—With respect to the complaint,
10 grievance, and appeals processes required under this sec-
11 tion, a health plan shall, upon the request of a covered
12 individual, provide the individual a written decision con-
13 cerning a complaint, grievance, or appeal in a timely fash-
14 ion.

15 (d) NON-IMPEDIMENT TO BENEFITS.—The com-
16 plaint, grievance, and appeals processes established in ac-
17 cordance with this section may not be used in any fashion
18 to discourage, prevent, or deny a covered individual from
19 receiving clinically necessary care in a timely manner.

20 (e) DUE PROCESS WITH RESPECT TO
21 CREDENTIALING.—

22 (1) RECEIPT OF INFORMATION.—A health pro-
23 vider who is subject to credentialing under section
24 305 shall, upon written request, receive from the
25 health plan any information obtained by the plan

1 during the credentialing process that, as determined
2 by the credentialing committee, does not meet the
3 credentialing standards of the plan, or that varies
4 substantially from the information provided to the
5 health plan by the health provider.

6 (2) SUBMISSION OF CORRECTIONS.—A health
7 plan shall have a formal, recorded (written or other-
8 wise) process by which a health provider may submit
9 supplemental information to the credentialing com-
10 mittee if the health provider determines that erro-
11 neous or misleading information has been previously
12 submitted. The health provider may request that
13 such information be reconsidered in the evaluation
14 for credentialing purposes.

15 (3) NO ENTITLEMENT.—

16 (A) IN GENERAL.—A health provider is
17 not entitled to be selected or retained by a
18 health plan as a participating or contracting
19 provider whether or not such provider meets the
20 credentialing standards established under sec-
21 tion 305.

22 (B) ECONOMIC CONSIDERATIONS.—If eco-
23 nomic considerations, including the health care
24 provider's patterns of expenditure per patient,

1 are part of a selection decision, objective cri-
 2 teria shall be used in examining such consider-
 3 ations and a written description of such criteria
 4 shall be provided to applicants, participating
 5 health providers, and enrollees. Any economic
 6 profiling of health providers must be adjusted
 7 to recognize case mix, severity of illness, and
 8 the age and gender of patients of a health pro-
 9 vider's practice that may account for higher or
 10 lower than expected costs, to the extent appro-
 11 priate data in this regard is available to the
 12 health plan.

13 (4) TERMINATION, REDUCTION, OR WITH-
 14 DRAWAL.—

15 (A) PROCEDURES.—A health plan shall de-
 16 velop and implement procedures for the report-
 17 ing, to appropriate authorities, of serious qual-
 18 ity deficiencies that result in the suspension or
 19 termination of a contract with a health pro-
 20 vider.

21 (B) REVIEW.—A health plan shall develop
 22 and implement policies and procedures under
 23 which the plan reviews the contract privileges of
 24 health providers who—

- 1 (i) have seriously violated policies and
2 procedures of the health plan;
3 (ii) have lost their privilege to practice
4 with a contracting institutional provider; or
5 (iii) otherwise pose a threat to the
6 quality of service and care provided to the
7 enrollees of the health plan.

8 At a minimum, the policies and procedures im-
9 plemented under this subparagraph shall meet
10 the requirements of the Health Care Quality
11 Improvement Act of 1986.

12 (C) COMMUNICATION.—Health plans shall
13 not restrict nor inhibit communication between
14 providers and patients or penalize a provider
15 making public the failure of the health plan to
16 comply with the provisions of this Act.

17 (D) LIABILITY.—A health plan shall not
18 require a provider to sign any type of hold-
19 harmless agreement as a requirement for par-
20 ticipation in the health plan.

21 (E) DUE PROCESS.—The policies and pro-
22 cedures implemented under subparagraph (B)

1 shall include requirements for the timely notifi-
2 cation of the affected health provider of the rea-
3 sons for the reduction, withdrawal, or termi-
4 nation of privileges, and shall provide the health
5 provider with the right to appeal initially to the
6 health plan and subsequently, upon failure to
7 resolve a dispute, to an independent entity, the
8 determination of reduction, withdrawal, or ter-
9 mination. No reduction, withdrawal, or termi-
10 nation of privileges shall be made without
11 cause.

12 (F) AVAILABILITY.—A written copy of the
13 policies and procedures implemented under this
14 paragraph shall be made available to a health
15 provider on request prior to the time at which
16 the health provider contracts to provide services
17 under the plan.

18 **SEC. 307. CONFIDENTIALITY STANDARDS.**

19 (a) IN GENERAL.—A health plan shall ensure that
20 the confidentiality of specified enrollee patient information
21 and records is protected.

22 (b) POLICIES AND PROCEDURES.—A health plan
23 shall have written confidentiality policies and procedures.
24 Such policies and procedures shall, at a minimum—

1 (1) protect the confidentiality of enrollee pa-
 2 tient information within the administrative structure
 3 of the health plan with special attention to sensitive
 4 health conditions and history;

5 (2) protect health care record information;

6 (3) protect claim information;

7 (4) establish requirements for the release of in-
 8 formation; and

9 (5) inform health plan employees of the con-
 10 fidentiality policies and procedures and enforce com-
 11 pliance with such policies and procedures.

12 (c) PATIENT CARE PROVIDERS AND FACILITIES.—

13 A health plan shall ensure that providers, offices, and fa-
 14 cilities responsible for providing covered items or services
 15 to plan enrollees have implemented policies and procedures
 16 to prevent the unauthorized or inadvertent disclosure of
 17 confidential patient information to individuals who should
 18 not have access to such information.

19 (d) RELEASE OF INFORMATION.—An enrollee in a
 20 health plan shall have the opportunity to approve or dis-
 21 approve the release of identifiable personal patient infor-
 22 mation by the health plan, except where such release is
 23 required under applicable law.

1 **SEC. 308. DISCRIMINATION.**

2 (a) ENROLLEES.—A health plan (network or non-net-
 3 work) may not discriminate or engage (directly or through
 4 contractual arrangements) in any activity, including the
 5 selection of service area, that has the effect of discriminat-
 6 ing against an individual on the basis of race, culture, na-
 7 tional origin, gender, language, socio-economic status, age,
 8 disability, health status including genetic information, or
 9 anticipated utilization of health services.

10 (b) PROVIDERS.—A health plan may not discriminate
 11 in the selection of members of the health provider or pro-
 12 vider network (and in establishing the terms and condi-
 13 tions for membership in the network) of the plan based
 14 on—

- 15 (1) the race, national origin, culture, age, or
- 16 disability of the health provider; or
- 17 (2) the socio-economic status, disability, health
- 18 status, or anticipated utilization of health services of
- 19 the patients of the health provider.

20 **SEC. 309. PROHIBITION ON SELECTIVE MARKETING.**

21 A health plan may not engage in marketing or other
 22 practices intended to discourage or limit the issuance of
 23 health plans to individuals on the basis of health condition,
 24 geographic area, industry, or other risk factors.

1 **TITLE IV—MISCELLANEOUS**
2 **PROVISIONS**

3 **SEC. 401. ENFORCEMENT.**

4 (a) IN GENERAL.—A State shall prohibit the offering
5 or issuance of any health plan in such State if such plan
6 does not—

7 (1) have in place a utilization review program
8 that is certified by the State as meeting the require-
9 ments of title II;

10 (2) comply with the standards developed under
11 title III;

12 (3) have in place a credentialing program that
13 meets the requirements of section 305;

14 (4) comply with the requirements of title IV;
15 and

16 (5) meet any other requirements determined ap-
17 propriate by the Secretary.

18 (b) SELF-INSURED PLANS.—The Secretary of Labor
19 may take corrective action to terminate or disqualify a
20 self-insured plan that does not meet the standards devel-
21 oped under this subsection.

22 **SEC. 402. EFFECTIVE DATE.**

23 (a) IN GENERAL.—Except as otherwise provided in
24 this section, this Act shall take effect on the date of enact-
25 ment of this Act.

1 (b) STANDARDS.—The standards and programs re-
 2 quired under this Act shall apply to health plans beginning
 3 on January 1, 1999.

4 (c) OFFICE FOR CONSUMER INFORMATION, COUN-
 5 SELING, AND ASSISTANCE WITH HEALTH CARE.—A
 6 State shall have in place the Office required under section
 7 101 on January 1, 1999. The Secretary may award grants
 8 for the establishment of such Offices beginning on the
 9 date of enactment of this Act.

10 (d) OTHER REQUIREMENTS.—The requirements of
 11 title IV shall apply to health plans beginning on January
 12 1, 1999.

13 (e) REGULATIONS.—The Secretaries described in sec-
 14 tion 301(a) may promulgate regulations to carry out this
 15 Act.

16 **SEC. 403. PREEMPTION.**

17 Nothing in this Act shall be construed to preempt any
 18 State law, or the implementation of such a State law, that
 19 provides protections for individuals that are equivalent to
 20 or stricter than the provisions of this Act.

○